

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

40050

File No. \_\_\_\_\_  
Registered No. 107  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County Macon  
Township \_\_\_\_\_  
City Macon (No. \_\_\_\_\_)

Registration District No. 533  
Primary Registration District No. 3027

**2. FULL NAME** A. C. Nichols

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W -

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9 - 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
65 7 20

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Po. Officer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Morion Ind  
(STATE OR COUNTRY)

**PARENTS**  
10. NAME OF FATHER Ellis R Nichols  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Macon Co  
(STATE OR COUNTRY) Mo  
12. MAIDEN NAME OF MOTHER Hannah C Wright  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Macon Co  
(STATE OR COUNTRY) Mo

14. INFORMANT Harley Nichols  
(Address) Macon Mo

15. FILED 12/31/30 Mrs Luke Funkler  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 29 1930

17. I HEREBY CERTIFY that I attended deceased from Oct 27 1930 to Dec 29 1930 that I last saw him alive on Dec 29 1930 and that death occurred, on the date stated above, at 6 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Shock complicating Fracture right hip followed by Pneumonia (Lobar) -  
(duration) yrs. 2 mos. 2 da.

CONTRIBUTORY (SECONDARY) Dementia  
(duration) yrs. 1 mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED 21011  
IF NOT AT PLACE OF DEATH. 108

DID AN OPERATION PRECEDE DEATH? No DATE OF 8/29

WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? Cerebral  
(Signed) Deward Miller M. D.  
19 31 (Address) Macon Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woodlawn Cem DATE OF BURIAL Dec 31 1930

20. UNDERTAKER Admt Skinner ADDRESS Macon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 20 1931

1948

1948

1948

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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Macon  
Township .....  
City macon (No. ....)

Registration District No. 533  
Primary Registration District No. 3027

File No. ....  
Registered No. 107  
St. .... Ward

**2. FULL NAME**

(a) Residence. No. .... St., .... Ward, ....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work .....  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

**14.**

INFORMANT (Address)

**15.**

FILED 1/30/31 Mrs Luke Dunkel REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 29 1920

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Shock Complicating fractured right hip followed by pneumonia (lobar) (duration) yrs. mos. ds.  
CONTRIBUTORY Dementia (SECONDARY) Auto accident on Highway 5 - car upset on curve. (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address) ai

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1880

